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State Michigan

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17. NURSE-MIDWIFE SERVICES

Services rendered by nurse-midwives certified by the American College of Nurse-midwives are covered. The nurse midwife must have an alliance agreement that provides a safe mechanism for physician consultation, collaboration and referral. Services include family planning, limited laboratory work, minor gynecological services, and maternity care for normal uncomplicated deliveries.

10/1/84

The scope of nurse-midwifery involves the independent management of care of essentially normal pregnancies. The management of medically complicated pregnancies is the responsibility of the physician, and is beyond the scope of nurse-midwifery. Patients with high-risk conditions or complications must be referred to the care of a physician. Nurse-midwife services provided to women with medical complications are covered only if provided under physician supervision. They must be billed by the supervising physician. The supervising physician must be available to the nurse-midwife through direct communication, in person or by radio, telephone or telecommunication. The physician does not have to be on the premises.

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18. HOSPICE CARE

Medicaid is using Medicare guidelines for hospice coverage.

For a Medicare/Medicaid recipient, the hospice must complete a Medicaid enrollment form.

If a Medicare/Medicaid recipient revokes his/her Medicare hospice benefit, he/she is not eligible to enroll in the Medicaid hospice benefit. However, if the recipient becomes inappropriate for hospice care during Medicare's fourth benefit period, he/she may be discharged from hospice, then enroll in Medicaid's hospice benefit when again appropriate for hospice care.

The exceptions to the Medicare guidelines are:

- If the recipient receives hospice services longer than 210 days, the hospice medical director must recertify the recipient every 30 days thereafter.
- The 20% inpatient cap will be applied to Medicaid recipients. The aggregate dollar cap will **NOT** be applied to Medicaid recipients.
- Hospice services may be provided in adult foster care facilities and homes for the aged if the facility is licensed in Michigan and has a contract with the Medicaid enrolled hospice.

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19. CASE MANAGEMENT

See Supplement 1 to Attachment 3.1-A.

20. EXTENDED SERVICES TO PREGNANT WOMEN

a. The Program covers extended services for 60 days after delivery.

b. All necessary medical services related to pregnancy or services associated with medical conditions that may complicate pregnancy are covered, including:

1) Psychosocial/nutritional assessments when the recipient is referred for assessment by a physician or a certified nurse midwife and when the service is provided through a maternal support service provider certified to render this service by the department of public health. The assessment will be administered by a certified social worker, registered dietitian or nutritionist and/or public health nurse. The assessment will diagnose and identify the existence, nature or extent of psychosocial/nutritional deviation, if any, in a recipient (same for categorically needy and medically needy clients). 11/01/87

2) Maternal support services are covered when referred by a physician or certified nurse midwife. The maternal support services provider, through which these services are delivered, must be certified by the Michigan Department of Public Health. Practitioners rendering the service must be either staff of the certified maternal support services agency or under direct contract to that certified agency and must be state licensed, rendering service within the scope of practice defined by state law. Maternal support services consist of:

a) professional visits/interventions of a certified social worker, nutritionist/registered dietitian and/or a public health nurse for counselling to prevent disease, disability and other health conditions or their progression and to promote physical and mental health and efficiency, and

b) childbirth/parenting education programs that have been certified by the Michigan Department of Public Health and delivered by a licensed practitioner as defined under this item.

21. AMBULATORY PRENATAL CARE FOR PREGNANT WOMEN DURING PRESUMPTIVE ELIGIBILITY

Not a covered service.

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22. RESPIRATORY CARE

10/01/87

Respiratory care services for ventilator-dependent individuals require prior authorization by the Medical Services Administration. If the cost of providing home health care along with other services provided to the recipient in the home exceeds the cost of care in an alternative setting for more than 6 months, the recipient must be transferred to an alternative, less costly setting.

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23 OTHER MEDICAL CARE

a. Transportation (Same for categorically needy and medically needy clients)

Ambulance service to a hospital for inpatient services, or from a hospital on completion of an inpatient stay, is an allowable benefit when a physician has ordered the service. The physician's name must be indicated on the claim for payment when submitted by the provider of service.

Ambulance service to a hospital for emergency care is an allowable benefit. (Emergency is defined as any condition in which a delay in treatment may result in permanent injury or loss of life.) A physician's order is not required if the definition of emergency is met. However, the nature of the affliction which gave cause for emergency service must be clearly described on the claim for payment when submitted by the provider of the service. The return trip from an emergency situation is a covered service, if ordered by a physician because the patient required ambulance transportation based on his medical condition, whether or not there was an inpatient stay.

If the ambulance service is by air, it is covered only under the following circumstances:

1) Time and distance would be a hazard to the life of the patient, either to or from the hospital, and

2) The reason for hospitalization at the distantly located hospital is that comparable care and medical services are not available locally, and the reason for hospital admission is for medical or surgical therapy, not for diagnosis only.

c. Care and services provided in Christian Science sanatoria (Same for categorically needy and medically needy clients)

Admission must be upon the written direction of a physician or a certified Christian Science practitioner, who must periodically recertify need for care. The facility must be operated or listed and certified by the First Church of Christ Scientist, Boston, Massachusetts. The primary items and services covered include nursing and related services, bed and board, and certain supplies, equipment, and appliances used as part of the Christian Science method of healing.

*Renumbered - previously item 18

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d. **Skilled nursing facility services for patients under 21 years of age** (Same for categorically and medically needy clients.)

Coverage is the same as for patients over 21 (Item 4a, page 1h), with the following limitation:

Children under the age of 15 who need skilled nursing care must be referred to a facility specifically licensed by the Michigan Department of Public Health to care for children. However, the Director of the Department of Public Health may authorize individual exceptions upon written application by the child's parent or guardian.

e. **Emergency hospital services** (Same for categorically and medically needy clients).

Inpatient and outpatient hospital services for emergencies, defined as any condition in which a delay in treatment may result in permanent injury or loss of life, are covered in any hospital, whether or not the hospital is certified for the care of either children or adults under the program. Such services are covered within the service limits specified in items 1 and 2 above.

f. **Personal Care Services in a Recipient's Home** (Same for categorically and medically needy recipients).

Personal care services are interventions related to the recipient's physical requirements which enable the individual to receive medical services on an outpatient basis. Personal care services are intended to help the recipient carry out the activities of daily living (ADLs) including eating, toileting, bathing, grooming, dressing, and mobility (ambulation and transferring), as well as the instrumental activities of daily living (IADLs). These activities include personal laundry, light housekeeping , shopping and errands, meal planning and preparation, and self administration of medication. Personal care services may be hands-on assistance or guiding, directing, or prompting of ADLs or IADLs.

Personal care services are covered when ordered by a physician or a Medicaid-designated case manager, in accordance with a plan of care, and rendered by a qualified person. At the state's discretion, supervision of personal care services may be provided by a registered nurse.

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Personal care services are available to recipients living in their own homes, the home of another, licensed residential facilities of 16 or fewer beds, and licensed homes for the aged. Services may also be provided outside the home, to enable the recipients to participate in community activities. Personal care services are not separately covered in the inpatient or nursing facility setting.

When provided for minor children, personal care services must be shown to be a necessary supplement to usual parental care, justified by the high service needs of the family. High service needs are those needs which arise from a physical, medical, emotional, or mental impairment of the minor child, and which require significantly higher levels of intervention than those required by a child of the same age without similar impairments.

An assessment of the recipient will determine the level of service. Recipients with more basic needs may be served by adults who are capable of communicating with the recipient and being responsive to the recipient's needs. Recipients with more complex needs or more specialized problems must be served by individuals who demonstrate their competence by experience or training.

Providers shall be employees of agencies or qualified individuals. Providers may not be legally responsible relatives (i.e., spouse, parents, or guardians.)

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a) **Case Management:** 1) For clients in general FC/HA, including Veteran's Administration clients, a services worker is responsible for personally completing or coordinating the completion of items (2)(a) through (2)(e); 2) For clients in FC where the Department of Mental Health (DMH) or a Community Mental Health (CMH) agency has placement and service delivery responsibility, the case manager is responsible for items (2)(a) through (2)(d) but does not perform payment authorization. Contract residences directly bill DMH for personal care services; 3) For clients in FC where DMH/CMH has placement responsibility only, the case manager is to complete or coordinate items (2)(a) through (2)(e).

b) **Nursing Supervision:** 1) For clients in general FC/HA, registered nurses employed by the state agency perform annual reviews of needs assessment and plans of care, or more frequently if the client's condition warrants change(s) in the service plan; 2) For clients in FC where DMH/CMH has case management responsibility, registered nurses perform reviews at least annually and are employed or contracted by these agencies.

c) **Providers:** FC/HA providers must meet state licensing requirements, including training specifications.

d) **Recordkeeping:** The provider will retain the provider log with other pertinent client records at the residence.

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CASE MANAGEMENT SERVICES

A. Target Group:

See attached targeted group A.

B. Areas of State in which services will be provided:

|X| Entire State

|_| Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide.

C. Comparability of Services

|_| Services are provided in accordance with section 1902(a)(10)(B) of the Act.

|X| Services are not comparable in amount, duration and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services

Assessment; care/services plan development; linking/coordination of services; reassessment/follow-up; monitoring of services.

E. Qualification of Providers:

See attached.

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CASE MANAGEMENT SERVICES

A. TARGET GROUP:

Targeted Group A: This targeted group consists of functionally limited persons with multiple needs or a high level of vulnerability who, as shown by an assessment, require mental health case management. Such persons must have a primary diagnosis of either mental illness or developmental disability and a documented need for access to the continuum of mental health services offered by a Medicaid-enrolled mental health clinic services provider. Moreover, these persons must have a documented lack of capacity for indpendently accessing, and sustaining involvement with, needed services.

A person in this targeted group may reside in his own home, the household of another, or in a supervised residential setting.

D. Definition of Services (for all targeted groups)

1. Assessment - A case management provider must have the capacity to perform a written comprehensive assessment of a person's assets, deficits and needs. The following areas must be addressed when relevant.

   a. Identifying information (referral source, marital status, living arrangements, emergency contacts, source of assessment information).

   b. Physical health (health problems or concerns, current diagnosis, medications, treatments, sensory impairments, nutritional status, elimination problems).

   c. Activities of daily living (mobility levels, personal care, household chores, personal business, amount of assistance required).

   d. Social/emotional status (intellectual functioning, behavior problems or concerns, mental impairments, alcohol/drug abuse).

   e. Social relationships/support (informal care givers, i.e., family, friends, volunteers, pets; formal service providers; significant issues in relationships or social environment).